The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

2008-09 AIM Rate Development Changes
Summary of Proposed Model Contract Language Changes Incorporating Newly Proposed Capitation Payment Structure, including Provisions Affecting AIM-linked Infants and Other Changes Conforming to Regulations

(FIRST REVIEW)

EXHIBIT A

III. Enrollment

- Has been revised to delete references to infants since infants born to AIM mothers are now enrolled in Healthy Families, except infants born on or after July 1, 2004.
- Regulation citation has been updated to reflect the new numbering presented with the implementation of the 2006 Health Trailer Bill for AIM and HFP.

EXHIBIT B

I. Payment Provisions

- Has been revised to reflect a per subscriber per month payment and a supplemental delivery payment instead of one lump sum payment for subscribers enrolled after July 1, 2008.
- The separate 60-day payment for infants has been removed.
- Infant information has been removed from contractor performance.

ATTACHMENT II

- Provider Data File Requirements has been updated to reflect the requirement of reporting the National Provider Identification number.

EXHIBIT A
TABLE OF CONTENTS

EXHIBIT A
SCOPE OF WORK

I. INTRODUCTION

A. Act and Regulation

This Agreement is in accord with and pursuant to Sections 12695 et seq., Part 6.3 of Division 2 of the California Insurance Code which establishes and sets forth the Access for Infants and Mothers Program and shall hereinafter be called the Act. This Agreement is also pursuant to Title 10, Chapter 5.6, Access for Infants and Mothers, and Chapter 5.8, Healthy Families Program, of the California Code of Regulations ("CCR") which are adopted by the Managed Risk Medical Insurance Board to implement the program and shall hereinafter be called the program regulations. Terms and definitions used in the Act and program regulations will have their same and identical meanings in this Agreement.

B. Contractor's Basic Program Responsibility

This Agreement is entered into by the Contractor and the State for the purpose of the Contractor's providing health benefits for Access for Infants and Mothers (AIM) Program subscribers and their infant children resulting from an AIM sponsored pregnancy. The method of delivery of the health benefits shall be through a health maintenance organization (or exclusive provider arrangement) model of managed care.

C. Changing Health Care Providers or Service Area

1. The Contractor's participation in the Program is limited to the Contractor's licensed service area accepted by the State, as specified in Attachment I, Geographic Area Grid, except as mutually agreed.

2. The Contractor's organization shall consist of the list of health care providers to be provided quarterly to the State, pursuant to Item III.K. These providers (institutional and professional) are listed in the Contractor's Provider Directory. The Contractor agrees to provide copies of the Provider Directory to the State upon request.

3. The Contractor shall notify the State of any pending material change in the composition of its provider network, or its provider network contracts, at least sixty (60) days prior to the implementation of such change or immediately upon the Contractor's knowledge of change if knowledge is acquired in less than sixty (60) days. For the purposes of this provision, a material

change shall be one which could reasonably impair Contractor's ability to perform under this Agreement, or a decision to open a new region or expand program accessibility if enrollment has been limited.

4. Subject to the conditions of subsections I. D., geographic coverage in the Program may be changed only upon written approval by the State. The Contractor shall request such approval in writing at least sixty (60) days prior to the date the change will take place. Requests to change any coverage area shall include documentation of approval from the Contractor's state licensing agency. The State's approval or disapproval shall be in the form of a letter from the State to the Contractor. If the change requested is to withdraw from an area due to a plan initiated licensure change, the State shall cease new enrollment of subscribers in the area and the Contractor shall continue to maintain and provide services to subscribers in the area until the end of the benefit year. If the change requested is to withdraw from an area due to a plan initiated licensure removal, then the Program will hold a special enrollment pursuant to Exhibit B, Item I.E.

D. Dual Provision of AIM and Healthy Families Services

1. In addition to providing health benefits under AIM, the Contractor shall maintain a health plan contract with the State for the provision of health benefits under the State of California's Healthy Families Program (HFP).

2. The Contractor shall offer the same product line and geographic availability in this agreement as is offered under the health plan contract for the Healthy Families Program.

II. CONTRACT TERM

A. Term of Agreement

The term of this Agreement shall be from July 1, 2004 through June 30, 2007. Continuation of the Agreement beyond June 30, 2005 is contingent upon the Contractor's continuing participation as an HFP Contractor effective July 1, 2006.

B. Renewal of Agreement

There exists an option to negotiate an Agreement for one subsequent one-year term, which may be exercised by the State at its sole discretion. Exercise of this option shall take place no later than sixty (60) days prior to

the expiration date of this Agreement. Such extension shall be by an amendment to this Agreement. Reimbursement rates applicable to the subsequent one-year term shall be negotiated by the parties and included in the amendment. Renewal of the Agreement is contingent upon successful performance by the Contractor, as determined by the State at its sole discretion.

III. ENROLLMENT

A. Eligibility

All applicants who are determined eligible by the State in accordance with the Act and program regulations are eligible to enroll in the program, subject to space availability.

B. Conditions of Enrollment

1. The Contractor shall enroll all subscribers referred and transferred by the State, ~~and the resulting infants,~~ as required by the State in accordance with applicable law.

2. The State shall notify the subscriber in writing of enrollment with the Contractor, and the beginning date of coverage by the Contractor.

3. The State shall notify the Contractor no later than ten (10) days prior to the subscriber's effective date of coverage.

4. The Contractor agrees that in special circumstances the State may provide less than ten days' notice prior to a subscriber's effective date of coverage. Special circumstances shall be at the discretion of the State, but Contractor shall be notified of the special circumstance.

~~C. Infant Registration for Infants Born to AIM Subscribers Enrolled Prior to July 1, 2004~~

~~1. The Contractor agrees to notify subscribers that it is the subscriber's responsibility to notify the Contractor of the birth of the infant within 30 days of the infant's birth.~~

~~2. The Contractor agrees to contact all subscribers whose estimated date of delivery has passed to determine the outcome of the pregnancy, if the outcome is unknown to the Contractor.~~

~~3. The Contractor agrees to enroll infants born to subscribers of the program within five days of the Contractor's being notified of the birth of the infant, unless otherwise directed by the State.~~

~~4. The Contractor agrees to provide the following information regarding all subscriber pregnancies by the tenth day of each month for all infants enrolled in the previous month: live birth or other termination of pregnancy. For all live births, the Contractor agrees to provide the State with the following information: infant's name, infant's date of birth, infant's address, infant's gender, mother's name and identification number, and infant's birth weight. This information shall be provided in a manner and format to be specified by the State.~~

C~~D~~. Infant Registration for Infants Born to AIM Subscribers Enrolled on or after July 1, 2004

1. The Contractor agrees to notify each subscriber that it is her responsibility to notify the State of the birth of her infant, as well as to pay all premiums due, by the last day of the eleventh month following the month of birth, in order for her infant to be eligible for automatic enrollment in the Healthy Families Program from the date of birth. The notification shall include phone calls and letters. All notification attempts shall be documented in the Contractor's enrollment system.

2. The State shall provide recommended language for the subscriber notifications.

3. The Contractor shall call the subscriber within the two weeks prior to the estimated date of delivery to provide the information described in Item III.C~~D~~.1.

4. If the Contractor has not received the birth outcome information within 15 days after the estimated date of delivery, the Contractor shall send a letter to the subscriber with the information in Item III.C~~D~~.1.

5. If the Contractor receives notification from the State that the infant has not been enrolled in the Healthy Families Program by the second month following the month of the estimated date of delivery, the Contractor shall initiate three phone calls to the subscriber to provide the information in Item III.C~~D~~.1. The phone calls shall occur at different times on different days, Monday through Saturday, to the extent the Contractor conducts business on Saturday.

6. The Contractor agrees to provide the following information regarding all subscriber pregnancies: live birth or other termination of pregnancy. Within five days of the Contractor's being notified of the birth of an infant to a subscriber, the Contractor agrees to provide the State with the following information: infant's name, infant's date of birth, infant's address, infant's gender, mother's name and identification number, infant's birth weight, and infant's primary care provider. This information shall be provided in a manner and format to be specified by the State.

7. For purposes of receiving notification of an infant's birth, the Contractor may accept notification from the subscriber or from a health care provider that provided services to the subscriber or her infant.

8. If an infant is in need of immediate health care services and the Contractor has knowledge of this need at any time up to five o'clock p.m. on the tenth day of the second full calendar month of the infant's life, the Contractor shall notify the State of the infant's need for services in accordance with the requirements of Article 2, Section 2699.6608, subsection (hf) of the Healthy Families Program regulations, and shall provide the information specified in Section 2699.6608, subsections (ba) 1, (b) 2, and (b) 3, within the time frame specified in Section 2699.6608, subsection (hf).

DE. Disenrollment

1. Upon notification by the State, the Contractor shall disenroll the subscriber ~~and/or enrolled infants~~.

2. The Contractor shall inform the subscriber to send a request for disenrollment, in writing, directly to the AIM Administrative Vendor. In the event the Contractor receives such a request from a subscriber, the Contractor shall notify the State within five working days of receipt of the request for voluntary disenrollment. The State shall process the disenrollment request and notify the Contractor of the cancellation date.

3. In no event shall any individual subscriber ~~or infant~~ be entitled to benefits for health care services rendered, supplies or drugs received or expense incurred with a date of service subsequent to the termination of coverage.

EF. Commencement of Coverage

1. Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the State as the effective date of coverage.

~~2. Independent coverage shall commence for an infant born to a subscriber enrolled prior to July 1, 2004 upon birth.~~

F~~G~~. End of Coverage

1. Coverage shall end for enrolled women under this program at midnight of the sixtieth day after the birth of an infant born under the program or other termination of the pregnancy.

~~2. For an infant born to a subscriber enrolled prior to July 1, 2004, coverage shall end at midnight of the day before the infant's second birthday, or earlier if the Contractor is notified by the State.~~

2~~3~~. Notification of Coverage Termination

The Contractor shall notify the subscriber by mail of the end of coverage at least twenty days prior to the end of coverage of the subscriber ~~and of the infant~~.

G~~H~~. Identification Cards, Provider Directory and Evidence of Coverage

1. The Contractor shall issue to the subscriber ~~and enrolled infants~~ an Identification Card that includes the program name and logo, and Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber ~~and enrolled infants are~~ is entitled within 10 days of the State's notice to the Contractor of her enrollment. The Contractor shall also make a current Provider Directory available to any subscriber who requests one.

2. The Contractor shall by June 15 of each year provide subscribers with an updated Evidence of Coverage booklet, the contents of which have been approved by the State. The Contractor shall provide a Provider Directory whenever there is a material change in the Contractor's provider network. The Provider Directory shall indicate the language capabilities of providers, if bilingual capability is available.

3. Upon request, the Contractor will provide persons interested in enrollment with the Contractor through the program a copy of the Contractor's Evidence of Coverage booklet and Provider Directory within 10 business days of the request.

4. By July 1 of each year, the Contractor shall submit to the State ~~five~~ two (~~5~~2) print copies of the updated Evidence of Coverage booklet, one electronic copy of the final approved Evidence of Coverage booklet on compact disk, and one copy of the updated Provider Directory.

H~~I~~. Right to Services

Possession of a Contractor Identification Card confers no right to services or other benefits of the program. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the program. Therefore, any person receiving services or other benefits for which he or she is not then entitled pursuant to the provisions of this Agreement is personally responsible for the cost of all medical care.

I~~J~~. Enrollment Data

The State and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, and transfer information to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept this information via EDI. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and form that comply with HIPAA standards for electronic transactions and code sets.

2. The State shall develop an electronic bulletin board system, available 24 hours a day, excluding maintenance periods usually on Sundays, to provide the Contractor with enrollment reports.

3. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.

4. The State shall transmit to the Contractor enrollment and data files on a daily basis, reflecting the prior day's activity.

5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist

of a record count of the different record types in the daily enrollment files for the prior week's activity (weekly summary).

6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Time each Monday or by 4:00 a.m. Pacific Time Tuesday, when Monday is an official State holiday.

7. On a monthly basis, the State shall provide audit files of all eligibility activity for the Contractor, including, but not limited to, currently active subscribers and disenrolled subscribers.

8. The State shall transmit the files described in Items 1, 4, 5 and 7 to the Contractor at no charge.

9. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Items 4, 5 and 7 above within six months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Items 4, 5 and 7 above at the rate of $85 per hour or $250 per report or file, whichever cost is greater. The State shall waive the assembly and retransmission fee if the State determines that the original transmission file was corrupted or unusable.

10. With respect to Items 4, 5 and 7 above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There shall be no charge for the services of the State's plan liaison.

11. Prior to commencing work requested by the Contractor under Item 9, the State shall provide a cost estimate to the Contractor.

12. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor and shall post them to the electronic bulletin board. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.

13. The State shall conduct at least one meeting per year for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.

14. The Contractor agrees either to use the Program's unique Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

JK. Network Information Service

1. The Contractor agrees to provide, to the best of the Contractor's ability, complete and accurate data on its provider network in an electronic format to be determined by the State. The Contractor understands that the minimum data set requested by the State shall include the information on the Contractor's network outlined in Attachment II, Provider Data File Requirements. The information described in Attachment II may be expanded by the State with no less than ninety (90) days notice by the State. The Contractor agrees to provide additional data elements, as requested by the State, to the best of its ability. The Contractor understands that the State intends to use information provided pursuant to this section to assist potential and current applicants and subscribers in selecting a health plan, and that in doing so information provided to the State will be shared with the public.

2. The Contractor agrees to provide the provider network information listed in Attachment II to the State on a quarterly basis. The Contractor may update its provider network information on a monthly basis. The Contractor is required to provide data for the creation of the database to the State between the 11th and 25th of any submission month.

3. The State agrees to offer the Contractor, if the Contractor is unable to provide electronic files in the specified provider network formats, data capture services at the rate of $25 per hour.

4. The State agrees to offer the Contractor, if the Contractor so requests, an unscheduled update to the provider network information at the rate of $500 per update.

IV. COVERED AND EXCLUDED BENEFITS

A. Covered and Excluded Benefits

1. Except as otherwise required by any provision of applicable law, only those benefits described in Section 2699.300 of the program regulations will be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Section 2699.301 of the program regulations will not be covered benefits. The Contractor shall set out the plan of coverage in an Evidence of Coverage document and shall provide the document to each subscriber enrolled with the

Contractor. The Evidence of Coverage document shall be reviewed and approved by the State.

2. The health education service benefit described in Section 2699.300 of the program regulations shall consist, at minimum, of the following requirements:

   a. The Contractor agrees to encourage its participating providers to:

      (1) Provide a smoke free environment for patients.

      (2) Offer patients smoking cessation services and assistance in tobacco avoidance.

      (3) Include tobacco exposure questions in health history and review for family history of tobacco related conditions.

      (4) Encourage patients using tobacco products or exposed to second hand smoke to attend anti-tobacco use programs.

   b. The Contractor agrees to provide a Smoking Cessation Program to subscribers. This program is described in Attachment III, Plan Smoking Cessation Program.

   c. Anti-Tobacco Use Health Education Protocol

      The Contractor agrees to provide participating providers with copies of the anti-tobacco use health education protocol adopted by the State. The State's protocol is described in Attachment IV, Anti-Tobacco Use Health Education Protocol.

   d. Anti-Tobacco Use Provider Education

      The Contractor agrees to contact participating providers annually during the term of this Agreement to encourage participating providers to discuss anti-smoking techniques with their clients who smoke or are exposed to second-hand smoke. This may be done through Contractor's provider newsletter or in another manner chosen by the Contractor.

3. The Contractor shall make benefit and coverage determinations. All such determinations are subject to the appeals process set forth in Article 5. of the program regulations.

4. The Contractor shall implement primary care management, quality assurance and utilization management to appropriately control the utilization of services and to promote the quality and continuity of care.

B. Coverage for Services Prior to Enrollment

Payments for allowable coverage prior to enrollment shall be arranged by the State and shall not be the responsibility of the Contractor under this Agreement.

C. Exercise of Cost and Utilization Management

The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

D. Telephone Service For Subscribers

The Contractor agrees to provide a toll free number for subscriber inquiries. This phone service shall be available on regular business days from the hours of 8:30 am to 5:00 pm. Pacific Time. The Contractor shall provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor shall have the capability to provide telephone services via an interpretive service for all limited English proficient persons.

E. Provision of Linguistically Appropriate Services

1. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

2. The Contractor shall provide access to interpreter services for all limited English proficient subscribers seeking health services within the Contractor's network. The Contractor may use bilingual or multilingual staff who can interpret for providers or use contracted community-based organization for interpreter services. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services.

3. Contractor agrees that subscribers will not be required to or encouraged to utilize family members or friends as interpreters. After being informed of his/her right to use free interpreter services provided by the Contractor, subscribers may use an alternative interpreter of his/her choice at his/her cost. The Contractor shall encourage the use of qualified interpreters. The Contractor agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances, such as medical emergencies.

4. The Contractor shall inform subscribers of the availability of linguistic services.

5. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item III.~~JK~~. of this Exhibit.

F. Written Materials

1. The Contractor is encouraged to provide written translation of the Evidence of Coverage booklet or other written materials to subscribers who are unable to read the English version of these materials.

2. The Contractor shall ensure the quality of any materials that are translated into other languages. The Contractor is encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. The Contractor may use computer technology as part of the process for producing culturally and linguistically appropriate translations. Guidelines for developing a quality translation process are included in Attachment V, Translated Process Flowchart, of this Agreement.

G. Use of Community Clinics and County Hospitals

Contractor will make best effort to include, as part of its physician network and contracting hospital network, comprehensive primary care clinics to provide outpatient services, and county hospitals to provide inpatient services.

H. Grievance Procedure

Department of Managed Health Care Regulatees:

The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall provide a written response to subscriber grievances and resolution of subscriber grievances, as required by Contractor's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. These procedures shall be described in the Contractor's Evidence of Coverage booklet. The procedures shall include protocols for notifying subscribers of their right to appeal to the State in accordance with Article 5. of the program regulations.

I. Pre-existing Condition Coverage Exclusion Prohibition

The Contractor agrees that no pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.

J. Interpretation of Coverage

The Contractor, in its Evidence of Coverage booklet, shall provide clear and complete notice of terms of coverage to subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

K. Health Insurance Portability and Accountability Act of 1996 Conformity

The State and the Contractor understand that the policies issued pursuant to this Agreement constitute creditable coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996. The State shall issue the Certificates of Coverage for disenrolled subscribers.

V. EXCLUSIONS AND LIMITATIONS

A. Order of Benefit Determination

The coverage of this program shall not duplicate and shall pay secondary to any other valid and collectible medical coverage, except for the State of California Medi-Cal Program. The Contractor shall coordinate benefits with any other coverage available to subscribers ~~and infants~~.

B. Acts of Third Parties

1. If a subscriber ~~or enrolled infant~~ is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement only on condition that the subscriber shall be deemed:

   a. To have agreed to reimburse the plan administered by the Contractor to the extent of the reasonable value of services provided, immediately upon collection of damages covering those services by him or her, whether by action at law, settlement or otherwise; and

   b. To have provided the Contractor with a lien against recovery for such service to the extent of the cost of such services for the plan. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

2. For purposes of Item V.B.1.b. of this Exhibit, the cost of the service shall be determined to be the allowable amount paid to preferred providers for services in the geographic area where the services are rendered.

C. Workers' Compensation Insurance

If, pursuant to any Workers' Compensation of Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the plan, then the Contractor shall provide the benefits of this Agreement only on condition that the subscriber shall be deemed to have provided the Contractor with a lien to the extent of the reasonable value of the services provided by the plan. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be a reasonable charge for services in the geographic area where the services are rendered.

D. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Items V.B. and V.C. of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. The State understands and agrees that lien recoveries may be chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise

liens as may be reasonable and appropriately consistent with normal practices.

VI. REPORTING OF DATA

A. Data Collection Efforts

In order to maintain the fiscal integrity and program quality of the AIM Program, and to insure the ability of the State to complete the reporting requirements of the Act, the Contractor shall make every effort to collect necessary data.

B. Cost of Data Collection

The Contractor agrees that the cost of collection and transmittal of data shall be included as a part of the payments received by the Contractor pursuant to Exhibit B, Item I.B. of this Agreement.

C. Data Elements: Utilization and Provider Payments

The data elements to be reported by the Contractor to the State are contained in Attachment VI, AIM Program Record Layouts. The Contractor agrees to provide the data elements on a quarterly basis, and in a manner and format to be specified by the State. The State may make changes to the data elements in Attachment VI.

EXHIBIT B
TABLE OF CONTENTS

EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

I. PAYMENT PROVISIONS

A. General

The Contractor agrees to arrange for the provision of medical benefits and case management services for subscribers ~~and infants~~ as described in Exhibit A, Item IV. of this Agreement.

B. Fees Provided to Contractor

1. a. For subscribers enrolled prior to July 1, 2008, and ~~A~~as ~~specified in~~provided in ~~Items~~ I.C. ~~and I.D.~~ of this Exhibit, the State shall pay the Contractor a flat fee per subscriber for all services received by subscribers from the effective date of coverage through midnight of the 60th day following termination of the pregnancy. This fee is set forth in Attachment VII, Confidential Attachment, Rates of Payment.

   b. For subscribers enrolled on or after July 1, 2008:

      i. The state shall pay a per subscriber per month fee for all services received by subscribers from the effective date of coverage through termination of the pregnancy.

      ii. In addition to the payment described in Item I.B.1.b.i. of this exhibit, upon receipt of satisfactory documentation of the subscriber's delivery, the State shall pay a delivery payment.

   c. The rates for the payments described in Items I.B.1.a and I.B.1.b are set forth in Attachment VII, Confidential Attachment, Rates of Payment. Such payments shall be full compensation for the Contractor's services provided pursuant to this Agreement.

~~2. As specified in Items I.C. and I.D. of this Exhibit, the State shall pay the Contractor a flat fee per month per infant for all services received by infants born to subscribers who enrolled in the program prior to July 1, 2004. This monthly fee shall be paid during the first through twelfth months of the infant's life. This fee is set forth in Attachment VII, Confidential Attachment, Rates of Payment.~~

~~3. As specified in Items I.C. and I.D. of this Exhibit, the State shall pay the Contractor a flat fee per month per infant for all services received by infants born to subscribers who enrolled in the program prior to July 1, 2004, during the second twelve months of the infant's life. This fee is set forth in Attachment VII, Confidential Attachment, Rates of Payment.~~

2.4. Upon enrollment of the infant into the Healthy Families Program, ~~T~~the State shall pay for infants born to subscribers who enroll in the program on or after July 1, 2004, ~~through~~ pursuant to the Contractor's contract with the State for the Healthy Families Program.

3.~~5~~. In cases of subscriber eligibility and enrollment appeals which result in liability of health care costs by the State, the Contractor shall pay the provider for services delivered within 30 days of notification by the State of the appeal findings and claim reimbursement from the State within 45 days after notification by the State of the appeals findings. The State shall pay the Contractor the actual costs of services received. However, the Contractor shall reimburse and claim for such services at any discounted rate that the Contractor may have in place with the provider in the AIM program and that is accepted by the provider as payment in full. Such payments may only be made by the Contractor and paid by the State when the Contractor receives prior written direction from the State. In the appeal findings, the State shall indicate which services are reimbursable.

~~C. Payment Schedule~~

~~1. The State agrees to pay the fee described in item I.B.1. of this Exhibit by the end of the second month following the subscriber's effective date of coverage.~~

~~2. The State agrees to pay the flat fees described in Items I.B.2. and I.B.3. of this Exhibit on a monthly basis by the end of the month following the applicable month of coverage for each infant reported to the State by the Contractor in accordance with Exhibit A, Item III.C.~~

~~3. Payments made by the State pursuant to Item I.B.2. of this Exhibit shall begin for the month of the infant's birth and shall continue up to the infant's first birthday. In no event shall an amount greater than the sum of twelve (12) monthly payments be made by the State for an infant during the first twelve months of the infant's life.~~

~~4. Payments made by the State pursuant to Item I.B.3. of this Exhibit shall begin the month of the infant's first birthday and shall continue up to the infant's second birthday. In no event shall an amount greater than the sum of twelve (12) monthly payments be made by the State for an infant during the second twelve months of the infant's life.~~

~~D~~C. Reductions ~~to Fees~~of Payments for Subscribers Enrolled Prior to July 1, 2008

1. The State's payment as provided for in Item I.B.1.a of this Exhibit shall be reduced by 95% for those subscribers who do not utilize the Contractor's services within nine months of the date of enrollment.

2. The State's payment as provided for in Item I.B.1.a of this Exhibit shall be reduced by 75% if the mother transfers out of the Contractor's health plan prior to delivery of her infant.

3. The State's payment as provided for in Item I.B.1.a of this Exhibit shall be reduced by 25% if the mother transfers into the Contractor's health plan subsequent to being enrolled with another AIM contracting health plan.

~~E~~D. Special Enrollment Materials Cost

In any event of an early termination of this Agreement or the removal of coverage in a service area by the Contractor which requires a special open enrollment, the Contractor agrees to pay the State $9.00 per applicant for subscribers enrolled in the Contractor's plan who must be moved to another participating plan.

~~F~~E. Monthly Financial Reporting

1. The Contractor shall submit a monthly financial report and supporting documentation, to the State by the 10th day of each month, in a standardized electronic format specified by the State.

2. The financial report shall justify and request payment for services provided to program subscribers pursuant to Items I.B.1, and ~~I.B.2, I.B.3, I.D~~C.1, I.D.2, ~~and I.D.3~~ of this Exhibit.

3. Any financial report submitted as described under Items I.~~F~~E.1 and I.~~F~~E.2 above, after review and approval by the State, shall be considered valid and acceptable for processing of payment for services provided to program subscribers.

4. Any financial report received not completed in accordance with Items I.~~F~~E.1 and I.~~F~~E.2 above shall be considered unacceptable and returned to the Contractor unprocessed with an explanation of any problems with the financial report. The Contractor may resubmit an acceptable report. The State reserves the right to make minor corrections to the report and process the report for payment with the corrections.

5. Accepted financial reports shall be processed for payment in accordance with state regulations.

II. FISCAL CONTROL PROVISIONS

A. Cost Controls Provided by Contractor

The Contractor shall be responsible for providing routine monitoring of the cost, quantity, and quality of benefits provided by its participating providers to enrollees, for the purpose of determining whether the level, type, and cost of such benefits are appropriate to the health care needs of the enrollees. The Contractor's system of monitoring utilization shall include reporting to its providers of the findings of the Contractor's monitoring activity.

B. Recoveries and Third Party Payments

The Contractor agrees to pursue third party payments and recovery of costs for medical services provided to subscribers ~~and infants~~ in accord with Exhibit A, Item V.B. and the Contractor's standard Third Party Liability provisions as set forth in the Contractor's evidence of coverage brochure. The Contractor and the State shall equally share all such amounts recovered.

C. Payment Limitation

Only subscribers ~~and infants~~ whom the Contractor has been notified by the State are enrolled in the program, are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period of eligibility.

D. Final Reporting of Costs

The Contractor shall present to the State a final report labeled "FINAL REPORT," no later than 180 days after the effective date of termination of this Agreement, after which no further claims shall be made to the State under this Agreement, except as provided in Exhibit D, Item I.C. of this

Agreement. The final report shall be submitted in a format prescribed by the State.

E. Capped Appropriation

The Contractor understands and agrees that this program of the State receives a capped appropriation and that there can be no expectation that the appropriation will be supplemented during the fiscal year. The program apportions its capitated budget by limiting the enrollment in the program if necessary. Enrollment may at all times be limited to enable the State to meet its fiscal obligations. To balance enrollment with fiscal capacity, the State will not permit additional enrollment until program funds are sufficient to pay the obligations under this Agreement.

F. Prior To Fiscal Year

It is mutually agreed between the parties that this Agreement may have been signed before ascertaining the availability of funds for the 2004/2005 State Fiscal Year. This Agreement is valid and enforceable only if sufficient funds are made available through the State Budget for the purposes of this program. This Agreement is subject to any additional restrictions, limitations, or conditions enacted in statute by the State Legislature which may affect the provision, terms or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature does not appropriate sufficient funds for this program, the Agreement shall be amended to reflect any reduction in funds and enrollment shall be curtailed by the State proportionately.

G. Crossing Fiscal Years and Program Changes

It is mutually understood between the parties that this Agreement has been written with a term which crosses state fiscal years, and therefore, before ascertaining the availability of legislative appropriation of funds for the 2005/2006 and 2006/2007 State Fiscal Years. This Agreement is valid and enforceable beyond June 30, 2005 only if sufficient funds are made available through the State Budget for the purposes of this program. This Agreement is subject to any additional restrictions, limitations, requirements or conditions enacted in statute by the State Legislature, or promulgated by the State which may affect the provision, terms or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature makes any such changes or does not appropriate sufficient funds for this program, the Agreement shall be amended to reflect any such changes or reduction in funds.

H. Perinatal Insurance Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the Perinatal Insurance Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Items I.B.~~.,~~ . and I.C.~~, and I.D.~~ of this Exhibit.

I. Contractor Performance and Remedy for Non-Performance

1. The State shall monitor the Contractor's compliance with the terms of this Agreement. The State shall attempt to work with the Contractor to assist the Contractor in fulfilling its obligations under this Agreement.

2. In addition to the right to terminate pursuant to Exhibit D, Item I, ~~-~~if the State finds the Contractor to be out of compliance with the terms of this Agreement the State may, upon written notice to the Contractor identifying the Contractor's failure to comply, immediately suspend enrollment in Contractor's health plan until such time that the Contractor is in compliance.

3. The following Contractor standards of performance shall be monitored by the State:

~~a. Exhibit A, Item III.C.4. Infant Information~~

a~~b~~. Exhibit A, Item III.C~~D~~.6. Infant Information

b~~c~~. Exhibit A, Item III.F~~G~~.3. Notification of Coverage Termination

c~~d~~. Exhibit A, Item III.G~~H~~.1. Identification Cards and Evidence of Coverage

d~~e~~. Exhibit A, Item IV.A.2.c. Anti-Tobacco Use Health Education Protocol

e~~f~~. Exhibit A, Item IV.A.2.d. Anti-Tobacco Use Provider Education

f~~g~~. Exhibit B, Item I.~~F~~E. Monthly Financial Reporting

g~~h~~. Exhibit A, Item VI.C. Data Elements: Utilization and Provider Payments

4. If, in the State's view, the Contractor has not fulfilled its contractual responsibilities with regard to the items identified in 3. above, the

State shall contact the Contractor and request that the Contractor meet the standard(s) forthwith. Such contact may be made via the telephone or in writing. If after such contact the State ascertains that the standards remain unmet, the State shall notify the Contractor in writing of the Contractor's lack of performance. If the Contractor does not improve performance to an acceptable level within 5 business days, the State may impose liquidated damages on the Contractor of $.15 per enrollee per day beginning on the sixth business day following notification. If the Contractor's performance does not improve within 15 additional business days from the first day liquidated damages were imposed, the State after written notice to the Contractor, may increase the liquidated damages to $.35 per enrollee per day on the 16th business day following the notification of non-performance until the Contractor is in compliance with the Contract. The State may impose concurrent liquidated damages for each of the items listed in 3. above.

5. The State may deduct liquidated damages due from the Contractor from amounts payable to the Contractor pursuant to Item I.B. of this Exhibit.

6. If the State determines that the Contractor's non-performance was caused in part by the State, the State shall reduce the damages proportionately.

7. The parties agree that the liquidated damages for failure to provide the deliverables and/or meet the contractual performance standards described herein are not susceptible to exact calculation in advance and that the liquidated damage amounts specified in this Agreement present an agreed estimate of what the future damages would be. The liquidated damages are not intended to be penalties.

J. Licensure

The Contractor certifies to the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Managed Health Care.

K. Fiscal Solvency

The Contractor agrees that it will at all times maintain the reserves required under the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated there under by the Department of Managed Health Care, including the Tangible Net Equity Regulations.

ATTACHMENT II
PROVIDER DATA FILE REQUIREMENTS

Provider Data File Requirements

Data Elements

The provider data file should contain one record for each unique provider location. In other words, a provider that practices in three different offices should be listed three times. Individual and facility records should be contained in separate files. If codes are used for any fields (e.g., specialties, hospital affiliations, etc.), an appropriate decode table should be included. The following items should be included, with one field per item:

For Both Individual Providers and Facilities

1. Address
2. Suite
3. City
4. State
5. ZIP
6. County
7. Phone number (with area code)
8. Plan Identifier
9. Tax ID
10. ~~PCP / Clinic ID~~National Provider Identification

For Facility Providers

1. Name
2. Facility Type (Hospital)

For Individual Providers

1. Social Security Number
2. DEA Number
3. Last Name
4. First Name
5. Middle Name or Initial
6. Suffix
7. Degree
8. Gender
9. Role (PCP, Referral, Self-Referral)
10. Specialty(ies)
11. State License Number
12. Date of Birth
13. Board Status
14. Open/Closed Practice Indicator
15. Languages Spoken
16. Hospital Affiliation(s)
17. ~~Clinic/Group/IPA Affiliation(s)~~National Provider Identification

Acceptable File Format

Delimited ASCII file with a field description is the only acceptable file format.

Acceptable Media Format

Internet transfer is the only acceptable media format. Feel free to use some form of common data compression (such as PKZIP). If data compression is used, please note the method of compression. Nine-track or other mainframe tape, 5 inch floppy and hard copy cannot be accepted.

Sample File Format

The file structures shown below represents a recommended file format for submitting physician (and other healthcare provider) data, and facility data. Note that the file format must comply with the requirements listed on page 1.

Provider File

Field Name	Width	Occurrences	Description / Definition
Plan Identifier	15	1	Name of the plan or panel
First	25	1	First name field
Middle	25	1	Middle name/initial field
Last	70	1	Last name field
Suffix	25	1	Jr, Sr, III, IV, etc.
Gender	1	1	Male, Female, or Unknown
Degree	25	1	MD, DO, etc.
Address	60	1	Street address or physician office location
Suite	30	1	Secondary address
City	45	1	
State	2	1	
Zip	5	1	
County	45	1	
Phone	10	1	Area code and number without dashes or spaces
Open Practice	1	1	Accepting patients, closed, unknown
~~PCP/Clinic ID~~National Provider Identification	15	1	This is an identifier meaningful to the health plan to be used for enrollment purposes.
DEA Number	15	1	Drug enforcement agency number
License number	9	1	
DOB	8	1	Physician's Date of Birth (MMDDYYYY)
SSN	9	1	Physician's Social Security Number
Tax ID	9	1	Federal Tax ID
Role	1	1	Role within the plan or panel; Primary care, Referral, or Self-referral
Specialty	60	8	Field indicating practice specialty; if a code is used, a translation table must be included
Spoken Languages Language Location/Provider	 60 1	8	Field indicating language spoken at the provider's location or by provider; if a code is used, a translation table must be included. Language Language spoken at location (L), by Provider (P), or both (B)
Board Status	1	8	Certified, Eligible, Not Certified, or Unknown
Hospital	60	16	Field indicating Physician's hospital affiliation
Clinic Group	50	8	Name of medical group, IPA or clinic

Facility File

Field Name	Width	Occurrences	Description / Definition
Plan Identifier	15	1	Name of the plan or panel
Hospital Name	70	1	Name of facility
Address	60	1	Address of facility
Suite	30	1	Secondary address
City	45	1	
State	2	1	
Zip	5	1	
County	45	1	
Phone	10	1	Area code and number without dashes or spaces
Tax ID	9	1	Federal Tax ID
Facility Type	8	1	Hospital, Clinics, SNF etc.

Access for Infants and Mothers (AIM) Program
Rate Development Template (RDT) for Contract Year July 1, 2008 – June 30, 2009

Instructions

Overview

The attached RDT is to be used to submit the AIM contractor's proposed payment rates for the July 1, 2008 – June 30, 2009 contract period. The AIM contractor will propose a monthly capitation rate as well as a supplemental maternity payment rate. The monthly capitation rate will be paid for each month of enrollment for an AIM mother and is intended to reimburse the AIM contractor for non-delivery related expenses. The supplemental maternity payment will be paid upon notice of delivery and is intended to reimburse the AIM contractor for the costs associated with the delivery as well as the first 60 days of care provided to the AIM mother's newborn. All payments will be made in accordance with terms and conditions specified in the AIM contract and are subject to negotiation.

Calculated fields are shaded in yellow and password-protected. Please provide values for all unshaded cells. For applicable cells, detailed instructions are available by placing the cursor over the cell. (Note: cells containing instructions will have a red flag in the upper-right hand corner.) A hardcopy of instructions is also available in schedule seven. Please follow all instructions carefully. Additional information may be requested to support rate negotiations.

A separate RDT submission will be required for each of the six HFP rating region in which the AIM contractor is proposing rates. *Contractor input is welcomed regarding the rating regions.*

Submission

All electronic versions of documents related to the contract amendments, including the RDT, must be received at AIMContractAmend08@mrmib.ca.gov by 5:00pm, March 3, 2008. In addition, by March 5, send two paper copies (one original and one copy) filed in three-hole binders, to:

Ms. Jackie Baker
Fiscal Operations Officer
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814

Schedules

The RDT includes the following schedules:

Schedule One – Certification

This certification must be signed in order to consider the RDT as submitted.

Schedule Two - Revenue, Expense and Utilization Statement (Dates of Service: 7/1/05 – 6/30/06)

Schedule Three – Revenue, Expense and Utilization Statement (Dates of Service: 7/1/06 – 6/30/07)

Schedules two and three represent the base data and should be completed using claims run-out for the most recent period available. There should be minimal IBNR. All medical expenses reported for the AIM mother's newborn should represent only those expenses incurred within the first 60 days of life.

Schedule Four – Trend Assumptions

Trend should be input from the midpoint of the two historical RDT reporting periods (7/1/05 – 6/30/06 and 7/1/06 – 6/30/07) to the midpoint of the contract year (July 1, 2008 – June 30, 2009). Note, there are separate utilization and unit cost trend inputs for each of the various categories of service.

"Other Adjustments" should be rarely used. Please provide an explanation as to why these factors are not included in utilization or unit cost.

Schedule Five - Projected Health Care Costs and Proposed Rates

Schedule Five is calculated based upon inputs from Schedules Two through Four with the exception of the profit/risk contingency assumptions. The schedule utilizes the base period data with trended and other adjustments applied to project forward to both a per-member-per-month (PMPM) rate and a maternity supplemental payment rate.

First, Mercer multiplied the base period credibility weights and the subcategory expenses. The product of this calculation was then multiplied by the respective subcategory trend factor and other adjustment factors found on the Schedule 4 tab. The sum of these products was calculated, deriving the total trended administrative expenses.

Second, to calculate the administrative expense as a percent of total expenses, Mercer divided the total trended administrative expense by the sum of total trended administrative expense and total trended medical expenses.

Schedule Six – Historical Claims Distribution

Schedule Six should consider the most recent claims run-out, but represent only claims for dates of service within the historical RDT periods specified in the schedule.

Schedule Seven - Detailed RDT Cell Instructions

Schedule seven represents the detailed instructions for applicable cells. These instructions are only a restatement of the instructions that are available by placing the cursor over a cell that has a red flag in the upper right-hand corner.

Plan Name: Plan XYZ

I herby attest that the reported information included in this RDT is accurate and complete for the California AIM program to the best of my knowledge.

I understand that whoever knowingly and willfully makes or causes to be made a false statement of representation on the reported schedules may be prosecuted under applicable state laws.

In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in termination in accordance with our contract.

By: _____ _____
Print Name Date

_____ _____
Signature and Title Phone number

1	BASE PERIOD TIME FRAME	7/1/2005 through 6/30/2006
2	CLAIMS RUN-OUT THROUGH	

3	REGION	

Plan XYZ
(Health Plan Name)
John Doe
(Preparer's Name and Phone Number)

		TOTAL
4	MEMBERSHIP STATISTICS	
5	Membership at end of base period	-
6	Member months during claims incurred period	-
7	Total number of deliveries (vaginal)	-
8	Total number of deliveries (cesarean section)	-
9	Total number of hospital admissions (vaginal)	-
10	Total number of hospital admissions (cesarean section)	-
11	Total number of hospital admissions (non-maternity)	-
12	Total number of hospital admissions (child)	-

		Total $
13	REVENUES	
14	Capitation revenue (mother)	$ -
15	Capitation revenue (child)	$ -
16	Investment Income	$ -
17	Other - Please Explain. _____	$ -
18	Total Revenue	$ -

		Description of Units (e.g., days, claims, units of service)	Total Units	Capitation	Fee-For-Service	Incurred-But-Not-Reported (IBNR)	Settlements, Shared Risk and Incentive Arrangements	Total $	PMPM / PMPD
19	MEDICAL EXPENSES (MOTHER)								
20	Inpatient Hospital								
21	Maternity (vaginal delivery)	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
22	Maternity (cesarean section)	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
23	Non-maternity	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
24	*Total Inpatient Hospital*		-	$ -	$ -	$ -	$ -	$ -	
25	Outpatient								
26	Outpatient facility	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
27	*Total Outpatient*		-	$ -	$ -	$ -	$ -	$ -	*#DIV/0!*
28	Professional								
29	Physician (delivery)	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
30	Physician (non-delivery)	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
31	*Total Professional*		-	$ -	$ -	$ -	$ -	$ -	
32	Ancillary Services								
33	Diagnostic lab & radiology	Procedures	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
34	Prescription drugs	Prescriptions	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
35	Other	Encounters	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
36	Net reinsurance costs			$ -	$ -			$ -	#DIV/0!
37	UM/QA costs			$ -	$ -			$ -	#DIV/0!
38	*Total Ancillary Services*		-	$ -	$ -	$ -	$ -	$ -	*#DIV/0!*
39	Total Medical Costs for the Mother		-	$ -	$ -	$ -	$ -	$ -	

		Description of Units (e.g., days, claims, units of service)	Total Units	Capitation	Fee-For-Service	Incurred-But-Not-Reported (IBNR)	Settlements, Shared Risk and Incentive Arrangements	Total $	PMPD
40	MEDICAL EXPENSES (CHILD)								
41	Inpatient Hospital								
42	Inpatient hospital (child)	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
43	*Total Inpatient Hospital*		-	$ -	$ -	$ -	$ -	$ -	*#DIV/0!*
44	Outpatient								
45	Outpatient facility	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
46	*Total Outpatient*		-	$ -	$ -	$ -	$ -	$ -	*#DIV/0!*
47	Professional								
48	Physician	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
49	*Total Professional*		-	$ -	$ -	$ -	$ -	$ -	*#DIV/0!*
50	Ancillary Services								
51	Diagnostic lab & radiology	Procedures	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
52	Prescription drugs	Prescriptions	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
53	Other	Encounters	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
54	Net reinsurance costs			$ -	$ -			$ -	#DIV/0!
55	UM/QA costs			$ -	$ -			$ -	#DIV/0!
56	*Total Ancillary Services*		-	$ -	$ -	$ -	$ -	$ -	*#DIV/0!*
57	Total Medical Costs for the Child		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!

		Total $
58	ADMINISTRATIVE EXPENSES	
59	Compensation	$ -
60	Data Processing	$ -
61	Management fees	$ -
62	Interest expense	$ -
63	Occupancy	$ -
64	Depreciation	$ -
65	Marketing	$ -
66	Other (identify) _____	$ -
67	Total Administrative Expenses	$ -

		Total $
68		
69	Profit/Loss	$ -
70	Combined mother's/child's medical loss ratio	#DIV/0!

1	BASE PERIOD TIME FRAME	7/1/2006 through 6/30/2007
2	CLAIMS RUN-OUT THROUGH	

3	REGION	

Plan XYZ
(Health Plan Name)
John Doe
(Preparer's Name and Phone Number)

		TOTAL
4	MEMBERSHIP STATISTICS	
5	Membership at end of base period	-
6	Member months during claims incurred period	-
7	Total number of deliveries (vaginal)	-
8	Total number of deliveries (cesarean section)	-
9	Total number of hospital admissions (vaginal)	-
10	Total number of hospital admissions (cesarean section)	-
11	Total number of hospital admissions (non-maternity)	-
12	Total number of hospital admissions (child)	-

		Total $
13	REVENUES	
14	Capitation revenue (mother)	$ -
15	Capitation revenue (child)	$ -
16	Investment Income	$ -
17	Other - Please Explain: _____	$ -
18	Total Revenue	$ -

		Description of Units (e.g., days, claims, units of service)	Total Units	Capitation	Fee-For-Service	Incurred-But-Not-Reported (IBNR)	Settlements, Shared Risk and Incentive Arrangements	Total $	PMPM / PMPD
19	MEDICAL EXPENSES (MOTHER)								
20	Inpatient Hospital								
21	Maternity (vaginal delivery)	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
22	Maternity (cesarean section)	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
23	Non-maternity	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
24	*Total Inpatient Hospital*		-	$ -	$ -	$ -	$ -	$ -	
25	Outpatient								
26	Outpatient facility	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
27	*Total Outpatient*		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
28	Professional								
29	Physician (delivery)	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
30	Physician (non-delivery)	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
31	*Total Professional*			$ -	$ -	$ -	$ -	$ -	
32	Ancillary Services								
33	Diagnostic lab & radiology	Procedures	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
34	Prescription drugs	Prescriptions	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
35	Other	Encounters	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
36	Net reinsurance costs			$ -	$ -			$ -	#DIV/0!
37	UM/QA costs			$ -	$ -			$ -	#DIV/0!
38	*Total Ancillary Services*		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
39	Total Medical Costs for the Mother		-	$ -	$ -	$ -	$ -	$ -	

		Description of Units (e.g., days, claims, units of service)	Total Units	Capitation	Fee-For-Service	Incurred-But-Not-Reported (IBNR)	Settlements, Shared Risk and Incentive Arrangements	Total $	PMPD
40	MEDICAL EXPENSES (CHILD)								
41	Inpatient Hospital								
42	Inpatient hospital (child)	Days	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
43	*Total Inpatient Hospital*		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
44	Outpatient								
45	Outpatient facility	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
46	*Total Outpatient*		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
47	Professional								
48	Physician	Visits	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
49	*Total Professional*		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
50	Ancillary Services								
51	Diagnostic lab & radiology	Procedures	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
52	Prescription drugs	Prescriptions	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
53	Other	Encounters	-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
54	Net reinsurance costs			$ -	$ -			$ -	#DIV/0!
55	UM/QA costs			$ -	$ -			$ -	#DIV/0!
56	*Total Ancillary Services*		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!
57	Total Medical Costs for the Child		-	$ -	$ -	$ -	$ -	$ -	#DIV/0!

		Total $
58	ADMINISTRATIVE EXPENSES	
59	Compensation	$ -
60	Data Processing	$ -
61	Management fees	$ -
62	Interest expense	$ -
63	Occupancy	$ -
64	Depreciation	$ -
65	Marketing	$ -
66	Other (identify): _____	$ -
67	Total Administrative Expenses	$ -

		Total $
68		
69	Profit/Loss	$ -
70	Combined mother's/child's medical loss ratio	#DIV/0!

1	MONTHS OF TREND	30

Plan XYZ
(Health Plan Name)
John Doe
(Preparer's Name and Phone Number)

		Annualized Trend Rates			Trend Factors			Other Adjustments	
2									
3	MEDICAL TREND (MOTHER)	Utilization	Unit Cost	Combined	Utilization	Unit Cost	Combined	Factors	Description
4	Inpatient hospital (maternity/vaginal delivery)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
5	Inpatient hospital (maternity/cesarean section)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
6	Inpatient hospital (non-maternity)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
7	Outpatient facility (mother)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
8	Physician (delivery)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
9	Physician (non-delivery)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
10	Diagnostic lab & radiology	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
11	Prescription drugs	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
12	Other	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
13	Net reinsurance costs			0.000%			1.000	1.100	
14	UM/QA costs			0.000%			1.000	1.100	

		Annualized Trend Rates			Trend Factors			Other Adjustments	
15									
16	MEDICAL TREND (CHILD)	Utilization	Unit Cost	Combined	Utilization	Unit Cost	Combined	Factors	Description
17	Inpatient hospital (child)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
18	Outpatient facility (child)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
19	Physician (child)	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
20	Diagnostic lab & radiology	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
21	Prescription drugs	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
22	Other	0.000%	0.000%	0.000%	1.000	1.000	1.000	1.100	
23	Net reinsurance costs			0.000%			1.000	1.100	
24	UM/QA costs			0.000%			1.000	1.100	

		Annualized Trend Rates		Trend Factors		Other Adjustments	
25							
26	ADMINISTRATIVE EXPENSES		Combined		Combined	Factors	Description
27	Compensation		0.000%		1.000	1.100	
28	Data Processing		0.000%		1.000	1.100	
29	Management fees		0.000%		1.000	1.100	
30	Interest expense		0.000%		1.000	1.100	
31	Occupancy		0.000%		1.000	1.100	
32	Depreciation		0.000%		1.000	1.100	
33	Marketing		0.000%		1.000	1.100	
34	Other (identify): _____		0.000%		1.000	1.100	

Source of utilization trend assumptions:

Source of unit cost trend assumptions:

Plan XYZ
(Health Plan Name)

John Doe
(Preparer's Name and Phone Number)

1	MONTHS OF TREND		30
2	BASE PERIOD (7/1/2005 through 6/30/2006) CREDIBILITY WEIGHT		50%
3	BASE PERIOD (7/1/2006 through 6/30/2007) CREDIBILITY WEIGHT		50%
4	AVERAGE LENGTH OF ENROLLMENT		0

	5 MEDICAL RATES (NON-DELIVERY)	Description of Units (e.g., days, claims, units of service)	Utilization per 1,000 Members	Unit Cost	Cost PMPM
6	Inpatient Hospital				
7	Non-maternity	Days	#DIV/0!	#DIV/0!	#DIV/0!
8	Total Inpatient Hospital		#DIV/0!	#DIV/0!	#DIV/0!
9	Outpatient				
10	Outpatient facility (mother)	Visits	#DIV/0!	#DIV/0!	#DIV/0!
11	Total Outpatient		#DIV/0!	#DIV/0!	#DIV/0!
12	Professional				
13	Physician (non-delivery)	Visits	#DIV/0!	#DIV/0!	#DIV/0!
14	Total Professional		#DIV/0!	#DIV/0!	#DIV/0!
15	Ancillary Services				
16	Diagnostic lab & radiology (mother)	Procedures	#DIV/0!	#DIV/0!	#DIV/0!
17	Prescription drugs (mother)	Prescriptions	#DIV/0!	#DIV/0!	#DIV/0!
18	Other (mother)	Encounters	#DIV/0!	#DIV/0!	#DIV/0!
19	Net reinsurance costs (mother)				#DIV/0!
20	UM/QA costs (mother)				#DIV/0!
21	Total Ancillary Services		#DIV/0!	#DIV/0!	#DIV/0!
22	Total Medical Costs for Non-Delivery		#DIV/0!	#DIV/0!	#DIV/0!

	23 MEDICAL RATES (DELIVERY)	Description of Units (e.g., days, claims, units of service)	Utilization per 1,000 Deliveries	Unit Cost	Cost PMPD
24	Inpatient Hospital				
25	Maternity (vaginal delivery)	Days	#DIV/0!	#DIV/0!	#DIV/0!
26	Maternity (cesarean section)	Days	#DIV/0!	#DIV/0!	#DIV/0!
27	Inpatient hospital (child)	Days	#DIV/0!	#DIV/0!	#DIV/0!
28	*Total Inpatient Hospital*		*#DIV/0!*	*#DIV/0!*	*#DIV/0!*
29	Outpatient				
30	Outpatient facility (child)	Visits	#DIV/0!	#DIV/0!	#DIV/0!
31	*Total Outpatient*		*#DIV/0!*	*#DIV/0!*	*#DIV/0!*
32	Professional				
33	Physician (delivery)	Visits	#DIV/0!	#DIV/0!	#DIV/0!
34	Physician (child)	Visits	#DIV/0!	#DIV/0!	#DIV/0!
35	*Total Professional*		*#DIV/0!*	*#DIV/0!*	*#DIV/0!*
36	Ancillary Services				
37	Diagnostic lab & radiology (child)	Procedures	#DIV/0!	#DIV/0!	#DIV/0!
38	Prescription drugs (child)	Prescriptions	#DIV/0!	#DIV/0!	#DIV/0!
39	Other (child)	Encounters	#DIV/0!	#DIV/0!	#DIV/0!
40	Net reinsurance costs (child)				#DIV/0!
41	UM/QA costs (child)				#DIV/0!
42	*Total Ancillary Services*		*#DIV/0!*	*#DIV/0!*	*#DIV/0!*
43	Total Medical Costs for Delivery		#DIV/0!	#DIV/0!	#DIV/0!

44	ADMINISTRATIVE EXPENSES		
45	Total trended administrative expenses		$ -
46	Total trended medical expenses		#DIV/0!
47	Administrative expenses as a % of total expenses		#DIV/0!
48	Profit/risk contingency (non-delivery PMPM)		0.000%
49	Profit/risk contingency (delivery PMPD)		0.000%

50	NON-DELIVERY PMPM RATE DEVELOPMENT		PMPM
51	Total medical costs PMPM for non-delivery		#DIV/0!
52	Administrative and profit/risk contingency load		#DIV/0!
53	Total non-delivery PMPM rate		#DIV/0!

54	DELIVERY PMPD RATE DEVELOPMENT		PMPD
55	Total medical costs PMPD for delivery		#DIV/0!
56	Administrative and profit/risk contingency load		#DIV/0!
57	Total delivery PMPD rate		#DIV/0!

Plan XYZ
(Health Plan Name)

John Doe
(Preparer's Name and Phone Number)

CLAIMS DISTRIBUTION (MOTHER)		
BASE PERIOD 7/1/2005 through 6/30/2006	Total Payments	Number of Claims
$0 to $5,000		
$5,001 to $10,000		
$10,001 to $25,000		
$25,001 to $50,000		
$50,001 to $75,000		
$75,001 to $100,000		
$100,001 to $150,000		
$150,001 to $200,000		
$200,001 to $300,000		
$300,001 to $500,000		
$500,001 to +		

CLAIMS DISTRIBUTION (CHILD)		
BASE PERIOD 7/1/2005 through 6/30/2006	Total Payments	Number of Claims
$0 to $5,000		
$5,001 to $10,000		
$10,001 to $25,000		
$25,001 to $50,000		
$50,001 to $75,000		
$75,001 to $100,000		
$100,001 to $150,000		
$150,001 to $200,000		
$200,001 to $300,000		
$300,001 to $500,000		
$500,001 to +		

CLAIMS DISTRIBUTION (MOTHER)		
BASE PERIOD	Total Payments	Number of Claims
$0 to $5,000		
$5,001 to $10,000		
$10,001 to $25,000		
$25,001 to $50,000		
$50,001 to $75,000		
$75,001 to $100,000		
$100,001 to $150,000		
$150,001 to $200,000		
$200,001 to $300,000		
$300,001 to $500,000		
$500,001 to +		

CLAIMS DISTRIBUTION (CHILD)		
BASE PERIOD	Total Payments	Number of Claims
$0 to $5,000		
$5,001 to $10,000		
$10,001 to $25,000		
$25,001 to $50,000		
$50,001 to $75,000		
$75,001 to $100,000		
$100,001 to $150,000		
$150,001 to $200,000		
$200,001 to $300,000		
$300,001 to $500,000		
$500,001 to +		

Detailed RDT Cell Instructions

Schedule 2	
Line/(Cell)	*Comment*
2	Please utilize the most current paid claims available at time of preparation.
7	Multiple births count as one delivery.
9	Please include all admissions related to the delivery event listed above.
10	Please include all admissions related to the delivery event listed above.
11	Please include all admissions not related to a delivery event (i.e. acute condition, false labor, etc.).
14	All capitation revenue is to be reported on an accrual basis and is associated with the base period stated above.
15	All capitation revenue is to be reported on an accrual basis and is associated with the base period stated above. Only report capitation revenue associated with the 0-2 month HFP child rate.
19/(Description)	These should be the number of units regardless of the category used to the right.
19/(Total Units)	Report total units of service across all methods of payment. (i.e., Capitation, Fee-For-Service, IBNR)
19/(IBNR)	Report IBNR claims, if applicable, beyond the claims run-out date listed above.
20	If the date of admission for an inpatient hospital claim is within the base period listed above, please include. Do not include inpatient hospital claims with a date of admission outside of the base period listed above.
21	Maternity charges will be calculated on a per member per delivery (PMPD) basis.
22	Maternity charges will be calculated on a per member per delivery (PMPD) basis.
26	An outpatient facility is defined as a facility where a facility fee is charged. Note, any emergency room charges associated with an inpatient admission should be reported above in the inpatient hospital section.
29	Please include only actual delivery costs. Physician charges will be calculated on a per member per delivery (PMPD) basis.
30	Please include all prenatal, postpartum, and other physicians. Physician charges will be calculated on a per member per month (PMPM) basis.
32	All ancillary services reported in this section were delivered on an outpatient basis.
35	This category should only be utilized if the cost is not associated with one of the other cost categories.
40/(Description)	These should be the number of units regardless of the category used to the right.
42	If the date of admission for an inpatient hospital claim is within the base period listed above, please include. Do not include inpatient hospital claims with a date of admission outside of the base period listed above.
42	Please include any inpatient stay for a child up to 60 days of life.
45	An outpatient facility is defined as a facility where a facility fee is charged. Note, any emergency room charges associated with an inpatient admission should be reported above in the inpatient hospital section.
53	This category should only be utilized if the cost is not associated with one of the other cost categories.

Schedule 3	
Line/(Cell)	*Comment*
2	Please utilize the most current paid claims available at time of preparation.
7	Multiple births count as one delivery.
9	Please include all admissions related to the delivery event listed above.
10	Please include all admissions related to the delivery event listed above.
11	Please include all admissions not related to a delivery event (i.e. acute condition, false labor, etc.).
14	All capitation revenue is to be reported on an accrual basis and is associated with the base period stated above.
15	All capitation revenue is to be reported on an accrual basis and is associated with the base period stated above. Only report capitation revenue associated with the 0-2 month HFP child rate.
19/(Description)	These should be the number of units regardless of the category used to the right.
19/(Total Units)	Report total units of service across all methods of payment. (i.e., Capitation, Fee-For-Service, IBNR)
19/(IBNR)	Report IBNR claims, if applicable, beyond the claims run-out date listed above.
20	If the date of admission for an inpatient hospital claim is within the base period listed above, please include. Do not include inpatient hospital claims with a date of admission outside of the base period listed above.
21	Maternity charges will be calculated on a per member per delivery (PMPD) basis.
22	Maternity charges will be calculated on a per member per delivery (PMPD) basis.
26	An outpatient facility is defined as a facility where a facility fee is charged. Note, any emergency room charges associated with an inpatient admission should be reported above in the inpatient hospital section.
29	Please include only actual delivery costs. Physician charges will be calculated on a per member per delivery (PMPD) basis.
30	Please include all prenatal, postpartum, and other physicians. Physician charges will be calculated on a per member per month (PMPM) basis.
32	All ancillary services reported in this section were delivered on an outpatient basis.
35	This category should only be utilized if the cost is not associated with one of the other cost categories.
40/(Description)	These should be the number of units regardless of the category used to the right.
42	If the date of admission for an inpatient hospital claim is within the base period listed above, please include. Do not include inpatient hospital claims with a date of admission outside of the base period listed above.
42	Please include any inpatient stay for a child up to 60 days of life.
45	An outpatient facility is defined as a facility where a facility fee is charged. Note, any emergency room charges associated with an inpatient admission should be reported above in the inpatient hospital section.
53	This category should only be utilized if the cost is not associated with one of the other cost categories.

Schedule 4	
Line	*Comment*
1	Months of trend is calculated from the midpoint of the combined base period (base year 1 and base year 2) to the midpoint of the contract year.
2	Please provide explanation as to why these factors are not included into utilization or unit cost factors.
3	Please note these are trend factors, not trend rates. Inserting a value of 1.0 would be the equivalent of 0.0% growth.
15	Please provide explanation as to why these factors are not included into utilization or unit cost factors.

Schedule 5	
Line	*Comment*
4	This must be calculated and reported to two decimal places. This is calculated by identifying all member months associated with individuals who disenrolled during the two year base period, regardless of whether the member month occurred prior to the base period divided by the total number of members who disenrolled during the two year base period.